PERSONAL INFORMATION

NAME _____ ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

RESIDENCE ADDRESS _____ CITY _____ STATE ____ ZIP _____

HOME PH# _____ [TransCellPhone] _____

PATIENT BIRTHDAY _____ PATIENT SS# _____

PATIENT OR PARENT EMPLOYED BY _____ WORK PH# _____

ATTENDING COLLEGE? ____ IF YES, WHERE _____

NAME OF PARENT OR SPOUSE _____

SPOUSE EMPLOYED BY _____ WORK PH# _____

RECALL INFORMATION EVERY ____ MONTHS ☐ NA

EMERGENCY CONTACT INFORMATION (NAME AND PHONE #) _____

DENTAL INSURANCE - PRIMARY INSURANCE PROVIDER

NAME OF INSURED (SUBSCRIBER) _____

INSURANCE COMPANY _____

INSURED ID# _____ GROUP # _____ PLAN NAME _____

DENTAL INSURANCE - SECONDARY INSURANCE PROVIDER

NAME OF INSURED (SUBSCRIBER) _____

INSURANCE COMPANY _____

INSURED ID# _____ GROUP # _____ PLAN NAME _____

HEALTH HISTORY

PHYSICIAN'S NAME _____ PH# _____ DATE OF LAST PHYSICAL _____

PHARMACY NAME _____ PH # _____

MARK ANY OF THE FOLLOWING THAT APPLY TO YOU NOW

- ☐ Heart failure
- ☐ Heart desease/Attack
- ☐ Angina Pectoris
- ☐ High Blood Preasure
- ☐ * Mitral Valve Prolapse
- ☐ * Heart Murmur
- ☐ * Rheumatic Fever
- ☐ * Congential Heart Lesions
- ☐ Heart Pace Maker
- ☐ Heart Surgery
- ☐ Cancer Type: _____
- ☐ Anemia
- ☐ Stroke
- ☐ Epilepsy or Seizures
- ☐ Psychiatric Treatment
- ☐ * Artificial Hip, Knee or other Joint
- ☐ Kidney disorders
- ☐ Ulcers
- ☐ Use of Tobacco Products
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Sinus Problems
- ☐ Hay Fever
- ☐ Allergies or Hives
- ☐ Diabetes
- ☐ Radiation Treatment
- ☐ Chemotherapy
- ☐ Arthritis
- ☐ Fainting or Dizzy Spells
- ☐ Sickle Cell Disease
- ☐ HIV positive, ARC, AIDS
- ☐ Alcoholism
- ☐ Drug Addiction
- ☐ Glaucoma
- ☐ Cortisone Medication
- ☐ Hepatitis Type: _____
- ☐ Liver Disease
- ☐ Jaundice
- ☐ Blood Transfusions
- ☐ Bleeding Disorder
- ☐ Bruise Easily
- ☐ Cold Sores
- ☐ Herpese
- ☐ * Any Type of Implant
- ☐ * Any Type of Transplant

* Do you need antibiotics before treatment because of prior medical treatment?
If Yes, explain _____

Women: Are you pregnant? ____ Nursing? ____ Taking birth control? ____

Please list ALL MEDICATIONS you are currently taking (including over the counter medications vitamins, or herbal remedies): _____

_____

Please list ALL ALLERGIES to medications: _____

_____

I HEARBY AUTHORIZE NECESSARY DENTAL TREATMENT AND ADMINISTERING OF ANESTHETICS AS MAY BE NECESSARY OR ADVISABLE IN THE DIAGNOSIS AND TREATMENT OF _____

Date: _____ Signature: _____

Relationship to patient: _____

I HAVE REVIEWED MY MEDICAL HISTORY AND THE ABOVE (INCUDING ANY CHANGES) IS ACCURATE

Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____

Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____

Adult Registration/Medical History